		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031351

Facility Name: WINDSOR NURSING & REHAB CENTER

Address: 10426 S. ROBERTS ROAD (Number) PALOS HILLS (City) 60465 (Zip Code)

County: COOK

Telephone Number: (708) 598-3460 **Fax #** (708) 598-0520

IDPA ID Number: 36-3468459

Date of Initial License for Current Owners: 10/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) BRUCE LEDERMAN
(Title) VICE PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	135	Skilled (SNF)	135	49,275	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,095	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,679	1,563	3,823	15,065	8
9	SNF/PED					9
10	ICF	30,387	9,742		40,129	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,066	11,305	3,823	55,194	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.49%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 115 and days of care provided 2,470

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	239,124	15,054	10,086	264,264		264,264	0	264,264			1
2	Food Purchase		172,772		172,772	(6,205)	166,567	(652)	165,915			2
3	Housekeeping	236,078	40,294	0	276,372		276,372	0	276,372			3
4	Laundry	62,972	18,565	4,209	85,746		85,746	0	85,746			4
5	Heat and Other Utilities			110,884	110,884		110,884	0	110,884			5
6	Maintenance	48,283	15,220	48,213	111,716		111,716	(3,702)	108,014			6
7	Other (specify):*			11,128	11,128		11,128	0	11,128			7
8	**TOTAL General Services**	586,457	261,905	184,520	1,032,882	(6,205)	1,026,677	(4,354)	1,022,323			8
	B. Health Care and Programs											
9	Medical Director	0		15,650	15,650		15,650	0	15,650			9
10	Nursing and Medical Records	2,023,618	146,434	12,554	2,182,606		2,182,606	0	2,182,606			10
10a	Therapy	169,211	2,138	236	171,585		171,585	0	171,585			10a
11	Activities	111,497	7,936	733	120,166		120,166	0	120,166			11
12	Social Services	26,486		4,800	31,286		31,286	0	31,286			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			580	580		580	0	580			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	2,330,812	156,508	34,553	2,521,873	0	2,521,873	0	2,521,873			16
	C. General Administration											
17	Administrative	194,148		0	194,148		194,148	0	194,148			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			86,193	86,193		86,193	0	86,193			19
20	Dues, Fees, Subscriptions & Promotions			46,708	46,708		46,708	(18,614)	28,094			20
21	Clerical & General Office Expenses	146,958	28,588	29,461	205,007		205,007	0	205,007			21
22	Employee Benefits & Payroll Taxes			491,161	491,161	6,205	497,366	0	497,366			22
23	Inservice Training & Education			2,415	2,415		2,415	0	2,415			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			246	246		246	0	246			25
26	Insurance-Prop.Liab.Malpractice			172,396	172,396		172,396	0	172,396			26
27	Other (specify):*			0	0		0	0	0			27
28	**TOTAL General Administration**	341,106	28,588	828,580	1,198,274	6,205	1,204,479	(18,614)	1,185,865			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,258,375	447,001	1,047,653	4,753,029	0	4,753,029	(22,968)	4,730,061			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER #0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			52,383	52,383		52,383	(5,297)	47,086			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			8,878	8,878		8,878	6,500	15,378			32
33	Real Estate Taxes			153,576	153,576		153,576	10,009	163,585			33
34	Rent-Facility & Grounds			871,549	871,549		871,549	0	871,549			34
35	Rent-Equipment & Vehicles			25,484	25,484		25,484	0	25,484			35
36	Other (specify):* OFFICE			44,971	44,971		44,971	(44,971)	0			36
37	TOTAL Ownership			1,156,841	1,156,841	0	1,156,841	(33,759)	1,123,082			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		90,326	16,409	106,735		106,735	0	106,735			39
40	Barber and Beauty Shops			320	320		320	0	320			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			111,143	111,143		111,143	0	111,143			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	90,326	127,872	218,198	0	218,198	0	218,198			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,258,375	537,327	2,332,366	6,128,068	0	6,128,068	(56,727)	6,071,341			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,983)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(652)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(204)	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	(7,810)	20		19
20	Contributions	(5,098)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(5,502)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	(3,702)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (32,951)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(23,776)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (23,776)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (56,727)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WINDSOR NURSING & REHAB CENTER

ID# 0031351

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -3702	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,702)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER **#** 0031351 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(652)	0	0	0	0	0	0	0	0	0	0	(652)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,702)	0	0	0	0	0	0	0	0	0	0	(3,702)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,354)	0	0	0	0	0	0	0	0	0	0	(4,354)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(18,614)	0	0	0	0	0	0	0	0	0	0	(18,614)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(18,614)	0	0	0	0	0	0	0	0	0	0	(18,614)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,968)	0	0	0	0	0	0	0	0	0	0	(22,968)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(9,983)	4,686	0	0	0	0	0	0	0	0	0	(5,297)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	6,500	0	0	0	0	0	0	0	0	0	6,500	32
33	Real Estate Taxes	0	10,009	0	0	0	0	0	0	0	0	0	10,009	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	(44,971)	0	0	0	0	0	0	0	0	0	(44,971)	36
37	**TOTAL Ownership**	(9,983)	(23,776)	0	0	0	0	0	0	0	0	0	(33,759)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(32,951)	(23,776)	0	0	0	0	0	0	0	0	0	(56,727)	45

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HAROLD LEDERMAN	0.4581	THE CLAREMONT REHAB & LIVING CENTER	BUFFALO GROVE	FREEDOM HOME C	BUFFALO GROVE	HOME CARE
BRUCE LEDERMAN	.4926	THE CLAREMONT OF LEE COUNTY	DIXON	WINDSOR HEALTH	CHICAGO	REAL ESTATE
ANDREA WEITZBERG	.0493			CARE MNGT		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	36	BOOKKEEPING OFFICE	$ 44,971	10418 S. ROBERTS RD.		$	$ (44,971)	1
2	V								2
3	V								3
4	V	30	DEPRECIATION		10418 S. ROBERTS RD.		4,686	4,686	4
5	V	32	INTEREST		10418 S. ROBERTS RD.		6,500	6,500	5
6	V	33	REAL ESTATE TAXES		10418 S. ROBERTS RD.		10,009	10,009	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 44,971			$ 21,195	$ * (23,776)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BRUCE LEDERMAN	VICE PRESIDENT	ADMIN	49.26				SALARY	$ 130,015	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 130,015		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	AMERICAN NATL BANK		X	WORKING CAPITAL	INTEREST			50,000			8,878	6
7												7
8												8
9	TOTAL Facility Related						$ 0	$ 50,000			$ 8,878	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 50,000			$ 8,878	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	304,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	309,562	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,062	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	312,150	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 163,636 For 19 93-97 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	(163,636)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	153,576	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	293,473	8
	1997	294,278	9
	1998	305,939	10
	1999	303,162	11
	2000	309,562	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINDSOR NURSING & REHAB CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031351

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-14-224-017-0000	NURSING HOME	$ 303,945.49	$ 303,945.49
2.	23-14-224-004-0000	NURSING HOME	$ 2,808.28	$ 2,808.28
3.	23-14-224-003-0000	NURSING HOME	$ 2,808.28	$ 2,808.28
4.			$	$
5.	23-14-224-012-0000	BOOKKEEPING OFFICE	$ 10,565.36	$ 7,043.57
6.	23-14-224-011-0000	BOOKKEEPING OFFICE	$ 4,448.10	$ 2,965.40
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 324,575.51	$ 319,571.02

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	94,210		$	1
2					2
3	TOTALS	94,210		$ 0	3

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1986	2,605	138	30	87	(51)	1,316	9
10	LEASEHOLD IMPROVEMENT			1988	7,660	243	30	255	12	3,432	10
11	LEASEHOLD IMPROVEMENT			1989	17,237	3,957	30	442	(3,515)	1,927	11
12	LEASEHOLD IMPROVEMENT			1989	1,600	51	30	41	(10)	1,379	12
13	LEASEHOLD IMPROVEMENT			1990	3,850	122	30	99	(23)	1,495	13
14	LEASEHOLD IMPROVEMENT			1991	21,282	676	30	546	(130)	5,551	14
15	LEASEHOLD IMPROVEMENT			1992	17,645	560	30	452	(108)	4,294	15
16	LEASEHOLD IMPROVEMENT			1993	13,966	443	31.5	358	(85)	3,222	16
17	LEASEHOLD IMPROVEMENT			1993	1,456	37	39	37		307	17
18	LEASEHOLD IMPROVEMENT			1994	6,777	174	39	174		1,314	18
19	FLOORING			1995	806	21	39	21		141	19
20	CONSTRUCT WALL			1995	641	16	39	16		106	20
21	NEW ROOF			1996	143,257	3,673	39	3,673		20,664	21
22	FLOOR REPAIR, FURNISH & INSTALL TILE			1996	37,055	950	39	950		5,107	22
23	REMODEL BATHROOM			1996	2,600	67	39	67		338	23
24	KITCHEN TILE			1997	2,300	59	39	59		283	24
25	DINING ROOM FIXTURES, PAINT & WALLPAPER			1997	1,090	28	39	28		129	25
26	FIRE ALARM SYSTEM			1998	109,410	2,805	39	2,805		9,461	26
27	HOT WATER BOILER			1998	18,132	465	39	465		1,414	27
28	FUEL STORAGE TANK			1999	3,558	91	39	91		251	28
29	ELECTRICAL WORK			1999	2,467	63	39	63		155	29
30	INSTALL CERAMIC TILES			1999	825	21	39	21		48	30
31	REPLACED SMOKE DETECTORS			2001	1,181	19	39	19		19	31
32	ROOFTOP AC/TUCKPOINTING			2001	19,276	204	39	204		204	32
33	CARPETING			2001	1,394	7	39	7		7	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 438,070	$ 14,890		$ 10,980	$ (3,910)	$ 62,564	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 327,687	$ 35,797	$ 30,021	$ (5,776)	10	$ 186,264	71
72	Current Year Purchases	27,974	1,696	1,399	(297)	10	1,399	72
73	Fully Depreciated Assets	65,273			0	10	65,273	73
74					0			74
75	TOTALS	$ 420,934	$ 37,493	$ 31,420	$ (6,073)		$ 252,936	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 859,004	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 52,383	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 42,400	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (9,983)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 315,500	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: PINE MANOR TERRACE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		203		$ 871,549	30		3
4	Additions							4
5								5
6								6
7	TOTAL		203		$ 871,549 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 01/01/86
Ending 09/30/16

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	09/30/2002	$ 881,737
13.	09/30/2003	$ 890,072
14.	09/30/2004	$ 904,055

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 11,524 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Activity / Maintenance	2000 Dodge Ram Van	$ 389.00	$ 4,668	17
18	Administrator	1999 Acura	516.00	5,754	18
19	Administrator	2002 Audi	580.00	5,638	19
20	Auto Fringe			(2,100)	20
21	TOTAL		$ 1,485.00	$ 13,960	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs			1,820			1,820	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			8,250			8,250	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				41,170		41,170	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES, RENTALS Other (specify): LABORATORY						55,495		55,495	13
14	TOTAL			$		$ 10,070	$ 96,665		$ 106,735	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER **#** 0031351 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,311,942		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	122,276		6
7	Other Prepaid Expenses	85,873		7
8	Accounts Receivable (owners or related parties)	181,736		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,701,827	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	438,070		15
16	Equipment, at Historical Cost	420,934		16
17	Accumulated Depreciation (book methods)	(434,391)		17
18	Deferred Charges	183,404		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 608,017	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,309,844	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 315,107	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	50,000		29
30	Accrued Salaries Payable	145,114		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,574		31
32	Accrued Real Estate Taxes(Sch.IX-B)	312,150		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 836,945	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	828,836		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 828,836	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,665,781	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 644,063	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,309,844	$ 0	48

***(See instructions.)**

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 441,850	1
2	Restatements (describe):		2
3		683	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 442,533	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	201,530	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 201,530	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 644,063	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,235,883	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,235,883	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	93,237	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 93,237	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	478	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 478	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,329,598	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,032,882	31
32	Health Care	2,521,873	32
33	General Administration	1,198,274	33
	B. Capital Expense		
34	Ownership	1,156,841	34
	C. Ancillary Expense		
35	Special Cost Centers	107,055	35
36	Provider Participation Fee	111,143	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,128,068	40
41	**Income before Income Taxes (line 30 minus line 40)****	201,530	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 201,530	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,800	2,080	$ 88,132	$ 42.37	1
2	Assistant Director of Nursing	160	160	3,581	22.38	2
3	Registered Nurses	14,660	17,015	391,772	23.03	3
4	Licensed Practical Nurses	21,605	23,063	449,391	19.49	4
5	Nurse Aides & Orderlies	74,585	80,784	858,484	10.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,398	3,680	79,713	21.66	7
8	Rehab/Therapy Aides	7,953	8,725	89,498	10.26	8
9	Activity Director	1,860	2,080	31,315	15.06	9
10	Activity Assistants	10,052	11,168	80,182	7.18	10
11	Social Service Workers	1,040	1,040	26,486	25.47	11
12	Dietician					12
13	Food Service Supervisor	1,870	2,080	39,339	18.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,430	25,017	199,785	7.99	15
16	Dishwashers					16
17	Maintenance Workers	2,329	2,649	48,283	18.23	17
18	Housekeepers	29,365	31,445	236,078	7.51	18
19	Laundry	6,565	7,397	62,972	8.51	19
20	Administrator	2,440	2,640	152,133	57.63	20
21	Assistant Administrator	1,840	2,080	42,015	20.20	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,922	13,138	146,958	11.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,736	6,240	144,645	23.18	31
32	Other Health Care(specify)					32
33	Other(specify) PSYCHO SOC	8,271	8,850	87,613	9.90	33
34	TOTAL (lines 1 - 33)	230,881	251,331	$ 3,258,375 *	$ 12.96	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 8,060	1-3	35
36	Medical Director	O	15,650	9-3	36
37	Medical Records Consultant	N	4,032	10-3	37
38	Nurse Consultant	T	2,891	10-3	38
39	Pharmacist Consultant	H	1,800	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		236	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	733	11-3	44
45	Social Service Consultant	E	4,800	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 38,202		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	24	$ 806	10-3	50
51	Licensed Practical Nurses	32	830	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	56	$ 1,636		53

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BRUCE LEDERMAN	ADMIN	49.26	$ 130,015
MARY ELLEN COLBY	ASST ADMIN	0	42,015
LARRY PUTZ	ADMIN	0	22,118
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 194,148

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		86,193
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 86,193

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 86,093
Unemployment Compensation Insurance		24,601
FICA Taxes		243,392
Employee Health Insurance		111,595
Employee Meals		6,205
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		3,485
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		21,995
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 497,366

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,242
Health Care Worker Background Check	354
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	13,312
TRUST FEES/FRANCHISE TX/ETC	204
CONTRIBUTIONS	5,098
DUES & SUBSCRIPTIONS	20,498
LICENSES & PERMITS	0
TRUST FEES/TAX/CONTRIBUTIONS	(5,302)
Less: Public Relations Expense	(7,810)
Non-allowable advertising	(5,502)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,094

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
EDUCATION AND SEMINAR	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1998	$ 4,513	3 YR	$	$ 1,504	$ 1,504	$ 753	$	$	$	$	$
2	PAINT/DECORATING	2001	5,345	3 YR				890	1,782	1,782	891		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 9,858		$	$ 1,504	$ 1,504	$ 1,643	$ 1,782	$ 1,782	$ 891	$	$

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER **#** 0031351 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? _____

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM $ 6,342.

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 73,555 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 111,143
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 6,205 Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: WINDSOR NURSING & REHAB CENTER #0031351 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,060	
	REPAIRS & MAINTENANCE		2,026	
			0	10,086
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		4,209	
			0	4,209
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		41,855	
	ELECTRICITY		53,999	
	WATER		13,748	
	CABLE TV - LOBBY		1,282	
			0	110,884
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,321	
	PAINTING & DECORATING		5,345	
	BUILDING REPAIRS		5,153	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		20,820	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,850	
	FIRE SERVICE		7,724	
			0	
			0	
			0	48,213
7	**OTHER**			
	SCAVENGER		10,908	
	SECURITY SERVICE		220	11,128
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	15,650	15,650

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	1,636	
	LABORATORY & XRAY EXPENSE		395	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,032	
	PHARMACY CONSULTANT	XVIII B 39-2	1,800	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	2,891	
	DENTAL		1,800	
			0	12,554
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	236	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	236
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	733	
			0	733
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	4,800	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	4,800
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER **#0031351** **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		580	580
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	15,466	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	70,727	
			0	86,193
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	COMMUNITY EDUCATION	VI 19 XIX F	7,810	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	5,502	
	EMPLOYEE WANT ADS	XIX F	7,242	
	CONTRIBUTIONS	VI 20 XIX F	75	
	DUES & SUBSCRIPTIONS	XIX F	20,498	
	LICENSES & PERMITS	XIX F	0	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	204	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,023	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	354	46,708
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		0	
	EQUIPMENT REPAIR & MAINTENANCE		11,581	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		185	
	TELEPHONE		17,695	
	MESSENGER SERVICE		0	
			0	29,461

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	243,392	
	UNEMPLOYMENT COMPENSATION	XIX D	24,601	
	WORKERS COMPENSATION INSURANC	XIX D	86,093	
	HOSPITALIZATION INSURANCE	XIX D	111,595	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,485	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	21,995	
	CHICAGO HEAD TAX	XIX D	0	491,161
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,415	2,415
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		246	246
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		172,396	172,396
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,047,653

WINDSOR NURSING & REHAB CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	172,772
LESS SALES TAX	(652)
NET FOOD	172,120
TOTAL PATIENT CENSUS	55,194
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	165582
ADD # EMPLOYEE MEALS/DAY	17
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	6205

PATIENT MEALS	165582
ADD EMPLOYEE MEALS	6205
TOTAL MEALS/YEAR	171787
NET FOOD	172120
DIVIDE TOTAL MEALS/YEAR	171787
COST PER MEAL	1
TIME EMPLOYEE MEALS	6205
EMPLOYEE MEAL RECLASSIFICATION	6205